FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034793

Facility Name: Collinsville Care Center

Address: 614 North Summit (Number) Collinsville (City) 62234 (Zip Code)

County: Madison

Telephone Number: 618-344-8476 **Fax #** 344-8483

HFS ID Number: 37-1239865001

Date of Initial License for Current Owners: 12/15/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Alice Green **Telephone Number:** 618-344-8476

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) David C Read Jr

(Firm Name & Address) 2810 Frank Scott Parkway West Ste 820, Belleville, IL 62223

(Telephone) 618-234-2273 Fax # 618-234-7777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 05/01/2005

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	115	Skilled (SNF)	110	38,300	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	115	TOTALS	110	38,300	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,104		1,088	2,192	8
9	SNF/PED					9
10	ICF	17,921	5,667		23,588	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,025	5,667	1,088	25,780	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.31%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/15/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/15/1988 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 1,059

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	135,216	9,378	4,939	149,533		149,533		149,533			1
2	Food Purchase		106,613		106,613		106,613		106,613			2
3	Housekeeping	49,242	13,217		62,459		62,459		62,459			3
4	Laundry	49,021	5,438	10,702	65,161		65,161		65,161			4
5	Heat and Other Utilities			74,668	74,668		74,668		74,668			5
6	Maintenance	38,017	9,947	27,255	75,219		75,219		75,219			6
7	Other (specify):*											7
8	**TOTAL General Services**	271,496	144,593	117,564	533,653		533,653		533,653			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	936,499	91,683	237,281	1,265,463	(40,256)	1,225,207		1,225,207			10
10a	Therapy					40,256	40,256		40,256			10a
11	Activities	34,311	3,813		38,124		38,124		38,124			11
12	Social Services	11,418			11,418		11,418		11,418			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	982,228	95,496	244,481	1,322,205		1,322,205		1,322,205			16
	C. General Administration											
17	Administrative	44,693			44,693		44,693		44,693			17
18	Directors Fees											18
19	Professional Services			35,325	35,325		35,325		35,325			19
20	Dues, Fees, Subscriptions & Promotions			40,650	40,650		40,650	(26,657)	13,993			20
21	Clerical & General Office Expenses	112,790	5,681	32,916	151,387		151,387		151,387			21
22	Employee Benefits & Payroll Taxes			217,366	217,366		217,366		217,366			22
23	Inservice Training & Education											23
24	Travel and Seminar			611	611		611		611			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			125,414	125,414		125,414		125,414			26
27	Other (specify):* **contrib,sales tax**			3,351	3,351		3,351	(3,351)				27
28	**TOTAL General Administration**	157,483	5,681	455,633	618,797		618,797	(30,008)	588,789			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,411,207	245,770	817,678	2,474,655		2,474,655	(30,008)	2,444,647			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Collinsville Care Center #0034793 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			87,341	87,341		87,341		87,341			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			130,204	130,204		130,204		130,204			32
33	Real Estate Taxes			64,829	64,829		64,829		64,829			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			6,280	6,280		6,280		6,280			35
36	Other (specify):*											36
37	**TOTAL Ownership**			288,654	288,654		288,654		288,654			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		6,353	331	6,684		6,684		6,684			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,450	57,450		57,450		57,450			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		6,353	57,781	64,134		64,134		64,134			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,411,207	252,123	1,164,113	2,827,443		2,827,443	(30,008)	2,797,435			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,204)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,025)	20		18
19	Entertainment				19
20	Contributions	(2,147)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(13,632)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (30,008)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (30,008)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Collinsville Care Center

ID# 0034793

Report Period Beginning: 01/01/2005

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Collinsville Care Center **#** 0034793 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(26,657)	0	0	0	0	0	0	0	0	0	0	(26,657)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(3,351)	0	0	0	0	0	0	0	0	0	0	(3,351)	27
28	**TOTAL General Administration**	(30,008)	0	0	0	0	0	0	0	0	0	0	(30,008)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,008)	0	0	0	0	0	0	0	0	0	0	(30,008)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Collinsville Care Center **#** 0034793 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(30,008)	0	0	0	0	0	0	0	0	0	0	(30,008)	45

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mike R. Riley	33.33%	Columbia Convalescent Center	Columbia			
Steven D. Brant	33.33%	Columbia Convalescent Center	Columbia			
		Four Fountains Convalescent Center	Belleville			
John R. Snyder	33.33%	Snyder's Vaughn Haven	Rushville			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Mike Riley	Director/Owner	Administrative	33.33	A	20	33.33		$		1
2	Steve Brant	Director/Owner	Administrative	33.33	B	20	33.33				2
3	John Snyder	Director/Owner	Administrative	33.33	C	20	33.33				3
4											4
5											5
6											6
7		A- Columbia Conv Ctr 51685									7
8		B- Four Fountains 60181									8
9		- Columbia Conv Ctr 38276									9
10		C- Snyders Vaughn 69000									10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Union Planters		X	Mortgage	$6,436.05	3/14/94	$ 1,852,758	$ 1,349,011	3/25/2006	5.2500	$ 74,288	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Union Planters		X	Revolving Line of Credit	interest only	7/13/98	600,000	599,007	3/25/2006	5.2500	55,980	6
7												7
8												8
9	TOTAL Facility Related				$6,436.05		$ 2,452,758	$ 1,948,018			$ 130,268	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,452,758	$ 1,948,018			$ 130,268	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Collinsville Care Center **#** 0034793 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	55,011	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	59,508	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,497	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	59,508	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	64,005	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	44,697	8
	2001	50,435	9
	2002	52,247	10
	2003	55,413	11
	2004	59,508	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Collinsville Care Center COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0034793

CONTACT PERSON REGARDING THIS REPORT Mike Myler

TELEPHONE 618-344-8476 FAX #: 618-344-8483

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-2-21-28-18-303-001	Nursing Home Johnson Addition	$ 56,791.00	$ 56,791.00
2.	13-2-21-28-18-303-003	Nursing Home Johnson Addition	$ 1,174.84	$ 1,174.84
3.	13-2-21-28-18-303-002	Nursing Home Johnson Addition	$ 1,403.57	$ 1,403.57
4.	13-2-21-28-18-303-004	Nursing Home Johnson Addition	$ 138.38	$ 138.38
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 59,507.79	$ 59,507.79

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 29,350 B. General Construction Type: Exterior Brick Frame steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	349,000	1988	$ 94,867	1
2	Resident Care	42,343	1993-2005	8,598	2
3	TOTALS	391,343		$ 103,465	3

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	115		1988	1962	$ 1,405,000	$ 35,125	27.5	$ 35,125	$	$ 600,052	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1989	4,950	99	50	99		1,592	9
10	Building Improvements			1990	174,944	3,869	20-50	3,869		60,838	10
11	Building Improvements			1991	6,022	120	50	120		1,797	11
12	Building Improvements			1992	107,436	2,148	30	2,148		29,213	12
13	Building Improvements			1993	70,752	1,856	40-50	1,856		14,520	13
14	Storage Building			1995	77,122	1,928	40	1,928		21,048	14
15	Building Improvements			1994	15,517	310	50	310		3,595	15
16	Archway			1994	8,139		10			8,139	16
17	Storage Building										17
18	Building Improvements			1995	38,417	768	50	768		8,132	18
19	Land Improvements			1995	6,883	344	20	344		3,642	19
20	Sewer Line Replacement			1996	11,224	561	10	561		5,424	20
21	Circulating Pumps- Heating System			1996	2,507	50	50	50		481	21
22	Painting,Wallpaper&Wood Refinishing for Patient Room			1996	35,405	708	50	708		6,786	22
23	Lens for Light Fixture			1996	567	11	50	11		109	23
24	Exhaust Fan & through the wall heating/AC unit			1996	3,996	80	50	80		766	24
25	Cement parking curbs			1996	1,928	39	50	39		370	25
26	Wall to Wall Carpet			1996	595	12	50	12		114	26
27	Resident room flooring			1996	14,000	280	50	280		2,682	27
28	Wall protector			1996	384	8	50	8		74	28
29	Hot water heater			1996	2,270	45	50	45		435	29
30	Flooring, boiler,painting,parking lot			1997	27,408	548	50	548		4,705	30
31	Walk in Cooler			1995	19,303	1,448	10	1,448		19,303	31
32											32
33	Disposition				(77,122)					(21,048)	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Landscaping	1998	$ 7,615	$ 381	20	$ 381	$	$ 2,887	37
38	Improvements	1998	1,800	36	50	36		273	38
39	Boiler & Pipes	1998	15,209	304	50	304		2,307	39
40	Airconditioners	1998	20,841	417	50	417		3,161	40
41	Comm Sys,handrails,signage,boiler	1999	31,379	628	50	628		4,131	41
42	Drain lines,flooring,fire wall	2000	24,323	486	39	486		2,716	42
43	Exterior renovation	2001	14,366	287	39	287		1,317	43
44	Landscaping	2002	1,250	62	20	62		224	44
45	Expansion tank, main panel,backdoor,boiler	2002	3,862	77	50	77		277	45
46	Roof	2002	23,583	590	40	590		1,818	46
47	Fire Alarm & sprinkler upgrades	2003	13,895	347	40	347		868	47
48	Fire Alarm & sprinkler upgrades	2004	9,401	235	40	235		352	48
49	Boiler pump & upgrades	2004	7,133	178	40	178		267	49
50	Disposal System	2004	4,176	104	40	104		156	50
51	Walk in freezer	2004	1,642	41	40	41		62	51
52	Landscaping	2004	1,750	87	20	87		139	52
53	Heat Pump	2005	3,745	91	20	91		91	53
54	Boiler	2005	2,849	36	20	36		36	54
55	Architectural work	2005	99,478	1,990	50	1,990		6,977	55
56									56
57									57
58	rounding		(4)	4		4		1	58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,245,940	$ 56,738		$ 56,738	$	$ 800,829	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 317,277	$ 30,226	$ 30,226	$		$ 222,907	71
72	Current Year Purchases	6,508	720	720		5-10	720	72
73	Fully Depreciated Assets	267,377					267,377	73
74								74
75	TOTALS	$ 591,162	$ 30,946	$ 30,946	$		$ 491,004	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,940,567	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 87,684	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 87,684	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,291,833	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 6,280 Description: office 4961, dietary 1319
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A Col 3	hrs	$	188	$ 13,478	$	188	$ 13,478	1
2	Licensed Speech and Language Development Therapist	10A Col 3	hrs		43	4,260		43	4,260	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A Col 3	hrs		321	22,443	75	321	22,518	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 Col 2	# of prescrpts				6,353		6,353	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	552	$ 40,181	$ 6,428	552	$ 46,609	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Collinsville Care Center # 0034793 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,115	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	632,066		3
4	Supply Inventory (priced at cost)	15,262		4
5	Short-Term Investments			5
6	Prepaid Insurance	134,038		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): accrued interest	11,060		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 807,541	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	103,465		13
14	Buildings, at Historical Cost	2,226,637		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	610,465		16
17	Accumulated Depreciation (book methods)	(1,291,491)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): goodwill	1,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,650,076	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,457,617	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 292,182	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	599,007		29
30	Accrued Salaries Payable	77,072		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,508		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to shareholder	15,093		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,042,862	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,349,011		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,349,011	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,391,873	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 65,744	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,457,617	$	48

***(See instructions.)**

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (252,772)	1	
2	Restatements (describe):		2	
3	**Restate accumulated depreciation and previous**		3	
4	**depreciation expense**	567,316	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 314,544	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(248,800)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (248,800)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 65,744	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,614,312	1
2	Discounts and Allowances for all Levels	(134,406)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,479,906	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	26,940	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 26,940	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	790	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	8,748	15
16	Rental of Facility Space		16
17	Sale of Drugs	41,854	17
18	Sale of Supplies to Non-Patients	3,475	18
19	Laboratory	2,603	19
20	Radiology and X-Ray	1,919	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 59,389	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc	11,373	28
28a	net gain on sale	1,035	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 12,408	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,578,643	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	533,653	31
32	Health Care	1,322,205	32
33	General Administration	618,797	33
	B. Capital Expense		
34	Ownership	288,654	34
	C. Ancillary Expense		
35	Special Cost Centers	6,684	35
36	Provider Participation Fee	57,450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,827,443	40
41	**Income before Income Taxes (line 30 minus line 40)****	(248,800)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (248,800)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
return not complete

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 49,224	$ 23.67	1
2	Assistant Director of Nursing	1,320	1,320	21,977	16.65	2
3	Registered Nurses	4,905	5,217	108,758	20.85	3
4	Licensed Practical Nurses	12,556	12,924	208,881	16.16	4
5	CNAs & Orderlies	46,847	48,737	528,052	10.83	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,820	1,900	19,607	10.32	8
9	Activity Director	1,893	1,973	18,640	9.45	9
10	Activity Assistants	1,938	1,986	15,671	7.89	10
11	Social Service Workers	836	916	11,418	12.47	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,090	13.02	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,575	15,051	108,126	7.18	15
16	Dishwashers					16
17	Maintenance Workers	3,888	3,968	38,017	9.58	17
18	Housekeepers	6,794	6,994	49,242	7.04	18
19	Laundry	5,612	5,812	49,021	8.43	19
20	Administrator	2,080	2,080	44,693	21.49	20
21	Assistant Administrator					21
22	Other Administrative	2,080	2,080	37,584	18.07	22
23	Office Manager					23
24	Clerical	4,500	4,680	75,206	16.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,804	119,798	$ 1,411,207 *	$ 11.78	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	150	$ 4,517	L1C3	35
36	Medical Director	varies	7,200	L9C3	36
37	Medical Records Consultant	12	465	L10C3	37
38	Nurse Consultant	3	167	L10C3	38
39	Pharmacist Consultant	21	840	L10C3	39
40	Physical Therapy Consultant	321	6,757	L10C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	507	$ 19,946		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	297	$ 11,632	L10C3	50
51	Licensed Practical Nurses	3,043	84,278	L10C3	51
52	Certified Nurse Assistants/Aides	4,833	89,846	L10C3	52
53	TOTAL (lines 50 - 52)	8,173	$ 185,756		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Alice Green	Administrator	0	$ 44,693
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 44,693

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
David C Read	consulting/reports	$ 3,639
Moore Renner & Simonin	accounting	3,796
Wessels & Pautsch	Legal	120
P. Michael Read	Legal	9,063
Greensfelder, Hemker, Gale	Legal	15,000
Van Ostrand $ Elvidge Kelly	Legal	2,107
Flynn & Guymon	Legal	625
John Delaney	Legal	225
Patricia Revelle	Legal	750
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 35,325

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,686
Unemployment Compensation Insurance	33,522
FICA Taxes	105,284
Employee Health Insurance	13,918
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other misc benefits	8,956
TOTAL (agree to Schedule V, line 22, col.8)	$ 217,366

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	10,204
Health Care Worker Background Check	250
(Indicate # of checks performed 21)	
Franchise tax	726
IHCA	1,587
COBRA publications	360
various other dues and subs	621
misc licenses fees	245
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,993

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	611
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 611

**See instructions.

Facility Name & ID Number Collinsville Care Center # 0034793 Report Period Beginning: 01/01/2005 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10							N/A						
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA 1587**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **26,040** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **57,450**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.